Washington State Department of Social & Health Services

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

FAMILY SUPPORT OPPORTUNITY (FSO) PLANNING WORKSHEET

EFFECTIVE DATE OF PLAN

REVIEW DATE

INDIVIDUAL'S NAME

SERIAL NUMBER

Extended Family, Friends, and neighbors

Community agencies and supports

Informal community groups/church

School: Public or private Infant Toddler/Day program

Family

DDD case manager(s) (with telephone number)

Specific information regarding:

Conferences/community projects

In home help (Medicaid Personal Care or state)

PROPOSED PLAN:

Community guide

Needs/concerns (please list numerically)

Flexible funding (per guidelines)

Main desire or dream for child's or individual's future

With my signature, I give permission to send copies to my community guide.

PARENT/GUARDIAN'S SIGNATURE

GOAL STATEMENT

If Comprehensive Assessment is not used, please complete numbers 1, 2, 3, and 4 below:

1. CURRENT DOCTOR	2. CURRENT DENTIST	3. EMERGENCY CONTACT

4. HEALTH CONCERNS

NEED AND CONCERNS (LIST BY NUMBER FROM FRONT PAGE)	GOALS/OUTCOMES	WHO WILL DO OR HELP?
		FREQUENCY/DURATION
		FUNDING (WAIVER? YES - NO)
		CURRENT STATUS
		DATE ACHIEVED (MM/DD/YYYY)

NEED AND CONCERNS (LIST BY NUMBER FROM FRONT PAGE)	GOALS/OUTCOMES	WHO WILL DO OR HELP?
		FREQUENCY/DURATION
		FUNDING (WAIVER? YES - NO)
		CURRENT STATUS
		DATE ACHIEVED (MM/DD/YYYY)

NEED AND CONCERNS (LIST BY NUMBER FROM FRONT PAGE)	GOALS/OUTCOMES	WHO WILL DO OR HELP?
		FREQUENCY/DURATION
		FUNDING (WAIVER? YES - NO)
		CURRENT STATUS
		DATE ACHIEVED (MM/DD/YYYY)

NEED AND CONCERNS (LIST BY NUMBER FROM FRONT PAGE)	GOALS/OUTCOMES	WHO WILL DO OR HELP?
		FREQUENCY/DURATION
		FUNDING (WAIVER? YES - NO)
		CURRENT STATUS
		DATE ACHIEVED (MM/DD/YYYY)

INDIVIDUAL'S NAME	DDD NUMBER	DATE

I understand that this INDIVIDUAL SERVICE PLAN does not guarantee that all services listed here will be provided. The delivery of services depends upon the availability of the services and/or funding.

I have reviewed the determinations of the Division of Developmental Disabilities as set forth in the INDIVIDUAL SERVICE PLAN. I agree to the services and goals in PART 3. I understand that I have the right to withdraw or not consent to the services offered in the PLAN. My rights to appeal the decisions of the Division of Developmental Disabilities have been explained to me. The procedures for making an appeal have been explained to me.

I agree that additional goals may be added to my INDIVIDUAL SERVICE PLAN, usually in case of an emergency, without a full review of the PLAN. New goals shall not be added without my prior approval and signature.

INDIVIDUAL'S SIGNATURE	PARENT/GUARDIAN'S SIGNATURE	CASE MANAGER'S SIGNATURE

REQUEST FOR ADMINISTRATIVE HEARING/APPEAL

I, _____ (check one of the following boxes)

- ☐ The person for whom services are requested,
- ☐ The parent/guardian for _____ who is under the age of 18 years,
- ☐ Guardian,

request an administrative hearing to review the decision of the division of Developmental Disabilities - Field Services as set forth in the INDIVIDUAL SERVICE PLAN.

I (check one box):

- ☐ Will be represented by an attorney.

  Name of attorney: _____

- ☐ Will **NOT** be represented by an attorney.

INDIVIDUAL'S SIGNATURE	PARENT/GUARDIAN'S SIGNATURE

STREET ADDRESS (INCLUDE CITY, STATE, AND ZIP CODE)	TELEPHONE NUMBER (INCLUDE AREAS CODE)

This form must be completed and returned within 30 days to appeal this decision.

You may look at and inspect all materials (documents, exhibits, etc.) available to the department regarding this decision. If you appeal this decision, a hearing will be scheduled within 10 days to review the decision.

To request a hearing, complete the above form and mail to the DIRECTOR, DIVISION OF DEVELOPMENTAL DISABILITIES, PO BOX 45310, OLYMPIA WA 98504-5310, or deliver to a Regional Office of the Division of Developmental Disabilities WITHIN 30 DAYS.